

SCHOOL REGISTRATION FORM

**PLEASE PRINT**

Method of transportation: Bus# \_\_\_\_\_ Walk \_\_\_\_\_ Pick up \_\_\_\_\_ Other \_\_\_\_\_

Name \_\_\_\_\_

Birth Date \_\_\_\_\_ <sup>Last</sup>  Male  Female <sup>First</sup> Grade \_\_\_\_\_ <sup>Middle</sup> Enrollment Date \_\_\_\_\_

Teacher's Name \_\_\_\_\_ Student Number \_\_\_\_\_

Ethnic Identity: White \_\_\_\_\_ Hispanic \_\_\_\_\_ American Indian \_\_\_\_\_ Black \_\_\_\_\_ Other \_\_\_\_\_

Are Languages other than English spoken in the home? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, please identify language spoken \_\_\_\_\_

**Parent and/or Guardian Information:**

Parent 1 \_\_\_\_\_

Parent 2 \_\_\_\_\_

Lives with \_\_\_\_\_

Example: Mother and Father, mother or father only, grandparent, guardian, foster, etc.

Mailing address: \_\_\_\_\_

Residence Address: \_\_\_\_\_

Home Phone \_\_\_\_\_ Unlisted: Yes \_\_\_\_\_ No \_\_\_\_\_ Cell \_\_\_\_\_

Father's Workplace \_\_\_\_\_

Name

Phone

Mothers Workplace \_\_\_\_\_

Name

Phone

**Emergency Contact Information:**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

**Medical Information:** Please complete health history section on reverse side

## ANNUAL HEALTH HISTORY

Student Name _____	Date of Birth _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Grade _____	School _____	Date _____
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*The following information is required to plan an appropriate program for your child and to be prepared for any emergency situation should on arise. This information may be shared with school staff on a "need to know basis."*

### MEDICAL HISTORY

- |  |  |
|--|--|
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Speech difficulty |
| <input type="checkbox"/> Hay fever       | <input type="checkbox"/> Fainting          |
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Nosebleeds        |
| <input type="checkbox"/> Heart disease   | <input type="checkbox"/> Headaches         |
| <input type="checkbox"/> Seizures/Spells | <input type="checkbox"/> Dental problems   |
| <input type="checkbox"/> Bone disease    | <input type="checkbox"/> Color Blindness   |
| <input type="checkbox"/> Vision problem  | <input type="checkbox"/> Physical handicap |
| <input type="checkbox"/> Hearing problem | <input type="checkbox"/> Other _____       |

### ALLERGIES (check all that apply)

- |                                 |                                  |  |                                  |
|---------------------------------|----------------------------------|--|----------------------------------|
| <input type="checkbox"/> Plants | <input type="checkbox"/> foods   | <input type="checkbox"/> Bees                  | <input type="checkbox"/> Insects |
| <input type="checkbox"/> Drugs  | <input type="checkbox"/> Animals | <input type="checkbox"/> Other (specify) _____ |                                  |

Please describe allergic reaction: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### MEDICATION (Medication requires physician and parent permission)

Is the medication needed for allergy?  
 At home?  Yes  No      At school?  Yes  No

Name of medication: \_\_\_\_\_

Is medication needed for any other condition? \_\_\_\_\_  
 \_\_\_\_\_

Is there anything else you can tell us that you feel will help the school staff to gether understand and with your child? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_

### MEDICAL INFORMATION

Was there a health problem or handicap present at birth?  No  Yes  
 What age was the diagnosis made? \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_

Name of physician treating for above diagnosis: \_\_\_\_\_  
 \_\_\_\_\_

Any operations, injuries, or hospitalizations related to diagnosis: \_\_\_\_\_  
 \_\_\_\_\_

Physical education activity:  Limited  Not Limited

If activity is to be limited, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Does your child wear:      Contact lenses?      Glasses?      Hearing aides?

Date \_\_\_\_\_      Doctor \_\_\_\_\_

Last eye examination: \_\_\_\_\_

Last dental examination: \_\_\_\_\_

Last medical examination: \_\_\_\_\_

### AUTHORIZATION

If emergency treatment is required for your child and you cannot be reached immediately, may the school authorities use their own judgment in calling on of the local doctors indicated above, or if now available, another doctor, to give treatment necessary for the health and welfare of your child?  
 Yes \_\_\_\_\_ No \_\_\_\_\_

If NO, please explain what action you desire the school to take: \_\_\_\_\_  
 \_\_\_\_\_

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_

**If a medical condition is diagnosed or there is a change in medication during the school year, please notify the School Nurse.**